PRINTED: 08/19/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ON	1B NO. 0938-0391
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155266				 07/27/2011	
			B. WIN				
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
				1	PY RUN AVENUE		
LIFE CAI	RE CENTER OF FO	ORT WAYNE		FORT \	NAYNE, IN46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	\neg	ID	1		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
	REGGEATORT OR	ESC IDENTIFY THO IN ORWANION	-	1710	·		DATE
F0000							
F0000	Complaints IN00 Complaint IN00 Federal/state defallegations are cir F226. Complaint IN00 due to lack of ev	ly 25, 26, 27, 2011 000167 :: 155266 00273740	F0	0000	This Plan of Correction is the center's crec allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of it alleged or conclusions set forth in the state deficiencies. The plan of correction is prepand/or executed because it is required by the provisions of federal and state law. We respectfully request the ISDH accept procompliance as evidence of compliance wit federal requirements for participation in the Medicare and/or Medicaid programs in plate a revisit survey.	f refacts of ared he	
	Sample: 8						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

54QN11

Facility ID:

000167

If continuation sheet

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING (X3) DATE SI COMPLE					
		155266	B. WIN			07/27/2	011
	PROVIDER OR SUPPLIER		'	1649 SF	NDDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0223 SS=D	These deficiencies cited in accordant. Quality review on 2011 by Bev Fau. The resident has the verbal, sexual, physicorporal punishments esclusion. The facility must nessecular, or physical punishment, or inv. Based on interviet the facility failed free from verbal adeficiency affector reviewed with all sample of 8. (Residential for the facility failed free from verbal adeficiency affector reviewed with all sample of 8. (Residential for the facility failed free from verbal adeficiency affector reviewed with all sample of 8. (Residential for the facility failed free from verbal adeficiency affector reviewed with all sample of 8. (Residential for the facility failed free from verbal adeficiency affector reviewed at the failed free from verbal adequates and the failed free from verbal adequates from the failed free from verbal adequates from verbal adequates from the failed free from verbal adequates from verba	es reflect State findings ce with 410 IAC 16.2 completed on July 28, lkner, RN the right to be free from visical, and mental abuse, ent, and involuntary of use verbal, mental, labuse, corporal coluntary seclusion. ews and record review, to ensure residents were and mental abuse. This ed 3 of 8 residents legations of abuse in a sident #B, #C, #D,)	F0	223	F 223 Free from abuse/involuntaryseclusion ged deficient practice: Residents affected by the alleged deficient practice: Three residents (#B, #C and #D) were found to have been affected by the alleged deficiency. Every resident is at risk to affected by this alleged deficient practice: The entire staff has been trained by the Staff Development Coordinator a Executive Director on the Abuse Policisigns	i be	08/02/2011
	report and had gi Administrator an	ven it to the d ADON (Assistant			of abuse, reporting of abus and professionalism (completed		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

54QN11

Facility ID:

000167

If continuation sheet

Page 2 of 19

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED	
		155266	B. WIN			07/27/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	PY RUN AVENUE		
LIFE CA	RE CENTER OF FO	ORT WAYNE		1	VAYNE, IN46805		
				L	7,1112, 11110000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	I	(5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	LETION
TAG	-	LSC IDENTIFYING INFORMATION)	-	TAG	<u> </u>	DA	I E
	Director of Nurs	O 7			8/2/11).	.	
	She indicated that	at on $7/5/11$, she received			Every instance of suspecte abuse of	u	
	a third complain	t about RN #1 from the			any kind will be treated		
	family of Reside	ent #D. The family			appropriately		
	member felt RN	#1 had been abusive to			using our Abuse Policy and		
	her sister.				state guidelines		
					to include immediate		
	Documentation	regarding the 6/27/11 and			suspension pending		
					investigation, notification of	f	
		s of mistreatment/abuse			the state within		
		n 7/25/11 at 2:00 p.m.,			24 hours, notification of		
	and indicated the	e following:			corporate compliance		
					entities, and a thorough		
	A Complaint/Co	ncern Registration Form,			investigation using the		
	dated 6/27/11, in	idicated on Saturday,			guidelines of state and faci	ity	
	1	at #B reported that RN #1			policies. Systems to ensure alleged		
	· ·	im" and "did not give him			deficient practice		
		ntil after 10:00 p.m."			does not recur:		
		•			Quarterly reminder training	of	
		ted LPN #2 witnessed the			entire staff		
	· ·	#2 " doesn't remember			on the abuse policy will be		
	,	ame) said just that she			conducted by		
	cursed and was a	angry @ (at) him, and			the Executive Director and		
	yelled at him."				Social Services.		
					Initial training by Social		
	A written statem	ent from RN #1, dated			Services on the Abuse		
		o.m., indicated she was			Policy with new associates		
	1 ^	y, 6/25/11. The statement			during orientation,		
	1	t, that she and Resident			Including recognizing abus management of	c ,	
	1 * *	·			tone and perception, and		
		e his medications at 8:15			proper reporting.		
	1 *	st smoke break but the			Executive Director will man	age	
	resident was not	in his room at the			suspected	Ĭ	
	designated time,	so she took the			abuse allegations immedia	ely	
	medications back	k to the medication cart.			following		
	The statement in	dicated around 8:35 p.m.,			state and facility policies.		
		nanded his medications.			Any allegations will be		
	Kesident #B den	nanded his medications.					

000167

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155266	B. WIN			07/27/20	011
		1	P. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PY RUN AVENUE		
LIFE CA	RE CENTER OF FO	ORT WAYNE			VAYNE, IN46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"Writer told residual	dent (Resident #B) 'if he			discussed in Resident		
	would quit acting	g like an ass I would get			Council for the group's		
	him his medicati	ion so he could go to bed.			approval of our findings and actions on a		
	Resident proceed	ded to state to nurse 'yeah			monthly basis.		
	_	u gotta job to do, so do it.'			Monitoring to ensure allege	h.	
	1	e stated 'I have until 10			deficient practice		
	p.m. to finish wh				does not recur:		
	p.m. to misii wi	int i need to			Abuse reporting and follow	up	
					actions added		
		D :			to monthly Process		
		laint/Concern Registration			Improvement meeting to		
		7/11, indicated RN #1			monitor for trends and		
	l *	nt #C and threatened to			completeness. Date of Completion: Augus	.,	
		e report indicated			nd , 2011	12	
	Resident #C felt	RN #1 was trying to			110, 2011		
	embarrass her.						
	A (1.11						
	1 ^	nt against RN #1, dated					
	•	imented by the ADON.					
	_	vas from the sister of					
		l indicated, in part, that on					
	1 ′	rould not let Resident #D					
	have a soda beca	ause she was diabetic. The					
	complaint report	t indicated Resident #C					
	was upset by the	way in which (RN #1's					
	name) told her sl	he couldn't have a soda.					
	She indicated he	er sister, Resident #D, felt					
		jail" and was "afraid"					
		eport also indicated LPN					
		esident #D's sister at home					
		#1 had been "verbally					
		dent #D on multiple					
	occasions.	dent "D on maniple					
	occasions.						
	On 7/6/11, LPN	#2 was terminated. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155266	B. WIN			07/27/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	· ·		1649 SI	PY RUN AVENUE		
	RE CENTER OF FO				VAYNE, IN46805		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
		n indicated LPN #2 called					
	1 *	r at home and accused					
		verbal abuse. LPN #2					
	1	his allegation to any					
	manager and she	e did not follow the					
	procedures outli	ned in our abuse					
	policies"						
	On 7/8/11, RN #	1 was given a verbal					
	warning indicati	ng "You will respect the					
	1	dents in this facility. You					
	*	ir tone and ensure that the					
	1	ver that you are angry or					
	1 -	king down to any one."					
	1	ction form indicated RN					
		training on 7/5/11 and					
		e Administrator, DON,					
	1	Administrator, DON,					
	and ADON.						
	On 7/11/11, the i	investigation of RN #1					
	1	d an initial report was					
	sent to the ISDH	•					
		Investigation Form, dated					
	1 ^	ed RN #1 was suspended					
	1	form indicated three					
		ide allegations against RN					
	1	inistrator interviewed the					
		ey were satisfied with the					
	response to their	-					
	1 ^	•					
	1 -	Form indicated further					
		s initiated by the Division					
		nd that all three residents					
	1	ey were talked to like a					
	child or demean	ed by the tone."					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155266	A. BUILDING B. WING		07/27/2011
NAME OF I	DOMED OF CURNITER			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		l l	SPY RUN AVENUE	
LIFE CAF	RE CENTER OF FC	PRT WAYNE	FORT	WAYNE, IN46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
		,			
	The final investig	gative report, dated			
	,	d the staff persons			
	comments were i	nappropriate.			
	The Termination	Notice form indicated			
	RN #1 was termi	nated on 7/15/11, " for			
	_	tly or rudely toward			
	others"				
	0 = 10 = 111				
	On 7/25/11 at 2:3	•			
		dicated he should have			
	-	when the allegations			
	were initially rec	eived.			
	The DON (Direc	tor of Nursing) indicated,			
	,	ons were reported, RN #1			
	_	on the unit where			
	Resident #B, #C,	and #D resided. The			
	DON indicated R	RN #1 worked on 6/28/11,			
	6/29/11, 6/30/11,	7/1/11, 7/4/11, 7/8/11.			
	7/9/11 and 7/10/1	11.			
		tigation Reporting and			
	-	, undated, provided by			
		r, was reviewed on			
	-	.m., and indicated:			
		st not be subjected to			
	abuse by anyone				
		ncludes, but is not limited			
		narassment, threats of			
	punishment, or d	•			
		efers to any use of oral, red language that includes			
	withen, or gestur	ed language mat includes	1	I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	A. BUILDING	00	COMP.	LETED
	PROVIDER OR SUPPLIER		1649 SI	ADDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE WAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	residentsregard comprehend, or of If the suspected passociate, the Ex place the associatinvestigatory [side completing the interpretation of the completing the interpretation of the completion of the complet	perpetrator is an ecutive Director shall te on immediate e] suspension while exercise to Complaint				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155266				07/27/2	011
			B. WINC		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER						
LIEE CAE		ADT MAYNE			PY RUN AVENUE		
LIFE CAP	RE CENTER OF FC	ORT WATNE		FURIV	VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0225		ot employ individuals who					
SS=D	-	guilty of abusing, neglecting,					
	•	dents by a court of law; or					
		entered into the State					
		concerning abuse, neglect,					
		sidents or misappropriation and report any knowledge it					
		a court of law against an					
		vould indicate unfitness for					
		aide or other facility staff to					
		de registry or licensing					
	authorities.						
		nsure that all alleged					
	•	g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
	•	ely to the administrator of other officials in accordance					
		ough established procedures					
		tate survey and certification					
	agency).	tato sarvoy and sortinoation					
	3 - 3,7						
	The facility must h	ave evidence that all					
	alleged violations	are thoroughly investigated,					
	•	further potential abuse while					
	the investigation is	s in progress.					
		nvestigations must be					
	•	ministrator or his designated					
	· · ·	d to other officials in state law (including to the					
		certification agency) within 5					
		e incident, and if the alleged					
		I appropriate corrective					
	action must be tak						
	Based on intervie	ews and record review,	F02	225	F 225 Investigate/Report		08/02/2011
		to ensure allegations of			Allegations/Individuals		
	mistreatment or abuse were reported to				Residents affected by the		
		•			a lleged deficient practice:		
	the to the ISDH (`			Three residents (#B, #C and	t	
	Department of H	ealth) in accordance with			#D)		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155266 07/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE State law, were reported immediately to were found to have beenaffected by this alleged the Administrator and failed to ensure deficiency. residents were protected during abuse Every resident is at risk to be investigations. This deficiency affected 3 affected by this of 8 residents reviewed with allegations of alleged deficient practice: abuse in a sample of 8. (Resident #B, #C, **Executive Director and Staff Development** #D,) C oordinator reeducated entire staff byin-service on reporting Findings include: (8/2/11) and identifying signs of abuse. On 7/22/11 at 10:55 a.m., the SSD (Social **Executive Director was** reeducated by Service Director) indicated she had s uperiors on the process and received a concern on 6/27/11 from two expectationswhen an residents (#B and #C), regarding the way allegation is made (7/17/11). they had been talked to and treated by RN Systems to ensure alleged #1. deficient practice does not recur:- Allegations She indicated she had written a concern will be followed up on report and had given it to the withinTwo hours of declaration. Administrator and ADON (Assistant - Staff members identified in an Director of Nursing). allegation will be suspended She indicated that on 7/5/11, she received immediately a third complaint about RN #1 from the pendinginvestigation. A thorough investigation will family of Resident #D. The family be conducted member felt RN #1 had been abusive to by Executive Director or her sister. designee followingstate and facility quidelines. Documentation regarding the 6/27/11 and Staff members found to have abused a resident 7/5/11 allegations of abuse were reviewed in any manner will be on 7/25/11 at 2:00 p.m., and indicated the terminated. following: An initial incident report will be supplied to the A Complaint/Concern Registration Form, ISDH within 24 hours and a follow up completedupon dated 6/27/11, indicated on Saturday, completion of investigation. 6/25/11, Resident #B reported that RN #1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155266	B. WIN			07/27/20)11
		<u> </u>	P. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PY RUN AVENUE		
LIFE CAI	RE CENTER OF FO	ORT WAYNE		1	VAYNE, IN46805		
(X4) ID		STATEMENT OF DEFICIENCIES	_	ID	,	— т	(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	DATE
		im" and "did not give him	1		Staff will have refresher		
		ntil after 10:00 p.m."			training on the Abuse		
		ted LPN #2 witnessed the			P olicy quarterly from the		
					Executive Director and Soci	al	
	· ·	#2 " doesn't remember			Services.		
	`	ame) said just that she			New associates will have		
		angry @ (at) him, and			abuse training provided by		
	yelled at him."				Social Services as partof the initial orientation before be		
					allowedto work in the facilit	- 1	
	A written statem	ent from RN #1, dated			Monitoring to ensure allege	- 1	
	6/27/11 at 2:15 p	o.m., indicated she was			deficient practice		
	working Saturda	y, 6/25/11. The statement			does not recur:		
	indicated, in part	t,			Abuse reporting and follow	up	
	·	ident #B agreed to give			actions added		
		at 8:15 p.m., after the last			to monthly Process		
		the resident was not in			Improvement meeting tomonitor for trends and		
		lesignated time, so she			completeness.Date of		
	took the medicat	•			Completion: August 2nd , 2	2011	
		The statement indicated			,		
	_	., Resident #B demanded					
		"Writer told resident					
	· '	he would quit acting like					
	١ -	et him his medication so					
	ı	ed. Resident proceeded to					
	1	ah I know cause you gotta					
		it.' In response nurse					
	stated 'I have un	til 10 p.m. to finish what I					
	need to.'"						
	A second Compl	aint/Concern Registration					
	_	7/11, indicated RN #1					
	· ·	nt #C and threatened to					
	l -	e report indicated					
		•					
	Kesident #C felt	RN #1 was trying to					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155266	A. BUI	LDING	00	COMPL 07/27/2	
		100200	B. WIN			0112112	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LIEE CAI	RE CENTER OF FO	NDT WAVNE		1	PY RUN AVENUE VAYNE, IN46805		
					VATINE, IN40003		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710	embarrass her.	ESC IDENTIF FING IN ORWANION)	-	1710	·		DATE
	embarrass ner.						
	A third commission	t against DN #1 datad					
	_	t against RN #1, dated mented by the ADON.					
	•	as from the sister of					
		indicated, in part, that on					
	•	ould not let Resident #D use she was diabetic. The					
		indicated Resident #D					
	1 2	way in which (RN #1's					
	· · · · · · · · · · · · · · · · · · ·	ne couldn't have a soda.					
		r sister, Resident #D, felt					
		ail" and was "afraid"					
	_	port also indicated, LPN					
	-	ent #D's sister at home					
		#1 had been "verbally					
		dent #D on multiple					
	occasions.						
	On 7/6/11 I DN :	#2 was terminated. The					
	· ·	indicated LPN #2 called					
	_	at home and accused					
		verbal abuse. LPN #2					
		nis allegation to any					
	_	did not follow the					
	procedures outlin	ied in our abuse					
	policies"						
	On 7/8/11 RN #	1 was given a verbal					
	· · · · · · · · · · · · · · · · · · ·	ng "You will respect the					
	_	dents in this facility. You					
	_	•					
		r tone and ensure that the					
		rer that you are angry or					
	dismissive or tall	king down to any one."					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND FLAN	OF CORRECTION	155266	A. BUII		00	07/27/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	₹		1	PY RUN AVENUE		
	RE CENTER OF FO			1	VAYNE, IN46805		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG	+	ction form indicated RN	-	IAG			DATE
		training on 7/5/11 and					
		Administrator, DON,					
	and ADON.	Administrator, DON,					
	and ADOIN.						
	On 7/11/11 the i	investigation of RN #1					
		id an initial report was					
	sent to the ISDH	-					
		Investigation Form, dated					
	1	ed RN #1 was suspended					
	1	form indicated three					
		ide allegations against					
		dministrator interviewed					
		I they were satisfied with					
	the response to t	-					
	_	Form indicated further					
	1 ^	s initiated by the Division					
		nd that all three residents					
		ey were talked to like a					
	child or demean	ed by the tone."					
	The final investi	gative report, dated					
	7/15/11, indicate	ed the staff persons					
	comments were	inappropriate.					
	The Torrein eties	Notice form indicated					
		inated on 7/15/11, " for					
	others"	tly or rudely toward					
	ouicis						
	Although allegat	tions of abuse against RN					
		d on 6/27/11 and 7/5/11					
	respectively, the	re was no documentation					
		spended or that the ISDH					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
ANDILAN	OF CORRECTION	155266	A. BUILDING	00	07/27/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			PY RUN AVENUE	
	RE CENTER OF FO		FORT \	WAYNE, IN46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		arding the allegations	into		DATE
		days after the first			
	allegation was re	•			
	anegation was re	portou).			
	On 7/25/11 at 2:3	30 p.m., the			
		dicated he should have			
	suspended RN #1	and reported the			
	•	use to the ISDH when			
	they were initiall	y received.			
	The DON (Direc	tor of Nursing) indicated			
	that after the alle	gations were reported,			
	RN #1 worked ev	venings on the unit where			
	Resident #B, #C,	and #D resided. The			
	DON indicated R	RN #1 worked on 6/28/11,			
	6/29/11, 6/30/11,	7/1/11, 7/4/11, 7/8/11.			
	7/9/11 and 7/10/1	11.			
		1			
	_	relates to Complaint			
	Number IN00092	2925			
	3.1-28(c)				
	3.1-28(d)				
	3.1 20(u)				
F0226		evelop and implement			
SS=D		d procedures that prohibit lect, and abuse of residents			
		ion of resident property.			
		ews and record review,	F0226	F226 Develop/Implement	08/02/2011
	the facility failed	to ensure their abuse		Abuse/Neglect, Etc Policies	5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266		A. BUILDING 00 COM		(X3) DATE S COMPL 07/27/2	ETED		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE				
LIFE CARE CENTER OF FORT WAYNE					AYNE, IN46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ATE	(X5) COMPLETION DATE
	suspending staff investigations, reabuse immediate the facility and rabuse to the ISD Department of H State law. This dresidents review abuse in a sample #D,) Findings include On 7/22/11 at 10 Service Director received a conceresidents (#B and they had been ta #1. She indicated she report and had g Administrator ar Director of Nurs She indicated that a third complain family of Reside member felt RN her sister. Documentation of 7/5/11 allegation of 7/5/11 allegation of the sister indicated that a third complain family of Reside member felt RN her sister.	eporting allegation of ely to the Administrator of eporting allegations of H (Indiana State lealth) in accordance with deficiency affected 3 of 8 ed with allegations of e of 8. (Resident #B, #C, etc.) 1:55 a.m., the SSD (Social indicated she had rn on 6/27/11 from two d #C), regarding the way liked to and treated by RN e had written a concerniven it to the ad ADON (Assistant			Residents affected by the alleged deficient practice: Three residents (#B, #C an #D) were found to have been affected by the alleged deficiency. Every resident is at risk to affected by this alleged deficient practice: The entire staff has been trained on the Abuse Policy, signs of abuse porting of abuse, and professional by the Executive Director and State Development Coordinator (completed 8/2 Every instance of suspected appropriately using our Abuse Policy and state guidelines to include immediate suspension pending investigation, notification of corporate compliance entities, and a thorough investigation using the guidelines of state and fact policies. Systems to ensure alleged deficient practice does not recur: Quarterly reminder training entire staff	be ise, ism ff 2/11). ed d	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155266 07/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE on the abuse policy by the **Executive Director** A Complaint/Concern Registration Form, and Social Services. dated 6/27/11, indicated on Saturday, Initial training on the Abuse 6/25/11, Resident #B reported that RN #1 Policy with had "cussed at him" and "did not give him new associates during his medication until after 10:00 p.m." orientation, including recognizing abuse, The form indicated LPN #2 witnessed the management of tone and event; and LPN #2 "... doesn't remember perception, and proper what (RN #1's name) said just that she reporting will be provided by cursed and was angry (a) (at) him, and Social Services. yelled at him." **Executive Director will manage** suspected abuse allegations immediately A written statement from RN #1, dated following 6/27/11 at 2:15 p.m., indicated she was state and facility policies. working Saturday, 6/25/11. The statement Monitoring to ensure alleged indicated, in part, deficient practice does not recur: that she and Resident #B agreed to give Abuse reporting and follow up his medications at 8:15 p.m., after the last actions added smoke break but the resident was not in to monthly Process his room at the designated time, so she Improvement meeting to took the medications back to the monitor for trends and medication cart. The statement indicated completeness. **Date of Completion: August 2** around 8:35 p.m., Resident #B demanded nd, 2011 his medications. "Writer told resident (Resident #B) 'if he would quit acting like an ass I would get him his medication so he could go to bed. Resident proceeded to state to nurse 'yeah I know cause you gotta job to do, so do it.' In response nurse stated 'I have until 10 p.m. to finish what I need to.'...." A second Complaint/Concern Registration

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155266		B. WING			07/27/2011		
		1	P		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEI	8		1	PY RUN AVENUE		
LIFE CA	RE CENTER OF FO	ORT WAYNE		1	VAYNE, IN46805		
					,		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
1710		· · · · · · · · · · · · · · · · · · ·		1710			Ditte
	1	7/11, indicated RN #1					
	1 *	nt #C and threatened to					
	1 ^	e report indicated					
		RN #1 was trying to					
	embarrass her.						
	A third complain	nt against RN #1, dated					
	7/5/11, was docu	imented by the ADON.					
	The complaint w	vas from the sister of					
	Resident #D and	indicated, in part, that on					
	7/5/11, RN #1 would not let Resident #D						
	have a soda because she was diabetic. The complaint report indicated Resident #C was upset by the way in which (RN #1's name) told her she couldn't have a soda. She indicated her sister, Resident #D, felt						
	1	jail" and was "afraid"					
	1 ^	eport also indicated LPN					
		nt #D's sister at home and					
	told her RN #1 had been "verbally						
	abusive" to Resi	dent #D on multiple					
	occasions. On 7/6/11, LPN #2 was terminated. The termination form indicated LPN #2 called a family member at home and accused another nurse of verbal abuse. LPN #2 "did not take this allegation to any manager and she did not follow the procedures outlined in our abuse policies"						
	0 7/0/11 733						
	1	1 was given a verbal					
	warning indicati	ng "You will respect the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155266		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	(X3) DATE SURVEY COMPLETED 07/27/2011			
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN46805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETION DATE			
	will manage you perception is new dismissive or tall. The corrective at #1 had received had met with the and ADON. On 7/11/11, the it was reopened an sent to the ISDH. The Suspension 7/12/11, indicate on 7/11/11. The residents had mark RN #1 and the A the residents and the response to the Suspension investigation was Office and "found felt either like the child or demeaned. The final investigation was The final investigation was comments were in the Termination RN #1 was termination RN #1 was termination RN #1 was termination in the correction of the Termination RN #1 was termination RN #1 was termination RN #1 was termination and the correction of the termination RN #1 was termination RN #1 was termination RN #1 was termination and the correction of the termination RN #1 was term	Investigation Form, dated d RN #1 was suspended form indicated three de allegations against dministrator interviewed they were satisfied with heir complaints. Form indicated further initiated by the Division d that all three residents ey were talked to like a ed by the tone."						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155266		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED 07/27/2011			ETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					PY RUN AVENUE		
	RE CENTER OF FO			FORT V	VAYNE, IN46805		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION DD FETY (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1710	†	tions of abuse against RN		1710	·		DATE
	"	d on 6/27/11 and 7/5/11					
		re was no documentation					
		spended or that the ISDH					
		arding the allegations					
	1	days after the first					
	allegation was re	-					
	On 7/25/11 at 2:	30 p.m., the					
		dicated he should have					
	suspended RN #1 and reported the						
	allegations of abuse to the ISDH when they were initially received. The DON (Director of Nursing) indicated that after the allegations were reported,						
	RN #1 worked e	venings on the unit where					
	Resident #B, #C	, and #D resided. The					
	DON indicated RN #1 worked on 6/28/11, 6/29/11, 6/30/11, 7/1/11, 7/4/11, 7/8/11. 7/9/11 and 7/10/11. The Abuse Investigation Reporting and Response Policy, undated, provided by the Administrator, was reviewed on 7/25/11 at 3:00 p.m., and indicated:						
		olationswhich involve					
	mistreatment, neglect, abuseare reported immediately to the Executive Director of the facility. Such violations will also be						
	1 -	agencies in accordance					
	with existing Sta						
		ncludes, but is not limited					
	to, humiliation, l	harassment, threats of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155266		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2011			
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN46805					
	SUMMARY S (EACH DEFICIENT REGULATORY OR punishment, or destricted disparaging and desidentsregard comprehend, or desidentsregard comprehend, or desidents(facility the suspected passociate, the Explace the association investigatory [side completing the interported to ISDH within five (5) we occurrence"	PRT WAYNE TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) reprivation. Pefers to any use of oral, red language that includes derogatory terms to less of age, ability to disability It or suspected incident of rexploitation is ty must contact the ISDH numediately upon uation exists Perpetrator is an ecutive Director shall the on immediate The suspension while nivestigation Investigations must be It in writing or by fax, working days of the relates to Complaint	PR	1649 SP	PY RUN AVENUE	TE .	(X5) COMPLETION DATE	